

## Just what the prez ordered: \$\$ for community clinics

By Casey Selix | Monday, July 6, 2009

You just don't expect to hear a director of a community health clinic — charged with taking care of the medically disenfranchised — sing the praises of former President George W. Bush.

But that's just what executive director Deanna Mills is espousing on a sunny, muggy day at the Community-University Health Care Center (CUHCC) in Minneapolis. How can this be? Didn't Bush build a rep for tax policy benefiting the upper-income brackets?

"I'm not a Bush fan in general but on this particular thing, I am a Bush fan," says Mills, who has worked four years at the 43-year-old center and in community health clinics for 30 years. "When he started his presidency, there were 500 to 600 community health centers across the country; by the time he left, there were 1,200. He really pushed expansion."

### Stimulus adds \$2 billion more

These days, Mills also is singing the praises of President Obama, who allocated \$2 billion for community health centers as part of the American Recovery and Reinvestment Act of 2009.

Federal funding for community health centers has drawn bipartisan support in recent years in an effort to provide primary care for the uninsured in clinics instead of hospital emergency rooms, where costs run much higher — especially for those patients who have delayed treatment. In Minnesota, federally supported centers are proud of their track records in prevention, with higher vaccination rates and lower infant mortality rates among patients, for example, than the general population.

During the Bush years, about \$1 billion was authorized to increase the number of federally qualified centers across the country. Though Minnesota ranked near the bottom of states receiving the Bush money, the state will benefit from the latest round.

CUHCC is in line to receive more than \$830,000 in stimulus money, \$215,000 of which will help expand the 160-member staff to serve more patients. The rest will go for capital needs such as replacing 20-year-old dental chairs with unreliable hydraulics. CUHCC's patient load has grown from 8,300 in 2001, during the last recession, to 10,500 this year and 13,000 anticipated next year "because the need is so great," says Mills. The Open Door Center in Mankato is to receive \$1.3 million.

"This is the biggest investment in community health centers since LBJ's war on poverty (in the 1960s)," notes Colleen McDonald, director of development and programs for CUHCC.

### Good news, as well as uncertainty

The 21st century landscape for community health clinics is dotted with good news and uncertainty. A bright spot is that a much needed infusion of cash is arriving at federally supported centers like CUHCC as the ranks of uninsured and underinsured patients swell during the recession.

Looming on the horizon is national health reform — and questions of how to care for more patients when there's already a shortage of primary care physicians and dentists willing to treat them for less than half of what they'd get from private insurance.

An ominous cloud for community health clinics and other providers in Minnesota is \$1.1 billion in cuts to state health programs over the next biennium. Some of the cuts went into effect July 1, but many on the

front lines say it's too early to determine the extent of the impact and how far federal programs and shrinking private donations will go to fill the gap. Pain is expected, though not as much pain as originally feared.

On the one hand, Gov. Tim Pawlenty's \$236 million in human services unallotments and his line-item veto of \$381 million for the General Assistance Medical Care (GAMC) program are certainly worrisome on top of a \$490 million reduction approved by the Legislature, observers say. Elimination of the GAMC program, which serves about 30,000 childless adults making up to 75 percent of federal poverty guidelines, is set for March 2010, which gives the Legislature a few weeks in the next session to try to resurrect the funding.

On the other hand, childless adults' eligibility for MinnesotaCare, a state public insurance program for low-income residents, was expanded this year to those with incomes up to 250 percent of federal poverty guidelines, which means a single with household income of \$27,075 could qualify for the program. But the big question is whether GAMC patients can afford any MinnesotaCare co-pays and premiums once they're moved to the program.

"It's doubtful they can," says Jonathan Watson, public policy director for the Minnesota Association of Community Health Centers, a trade group representing 17 federally qualified clinics (CUHCC is one). One strategy will be to try to move those patients diagnosed with "serious and persistent mental illness" to Medical Assistance (the state Medicaid program) by establishing that they have a mental health disability. Otherwise, Watson and others worry that GAMC patients will turn to hospital emergency rooms for care.

Having trouble keeping track of all these public programs and their acronyms? Later in the story, Portico Healthnet's director will explain how the nonprofit agency guides the uninsured through the labyrinth of public aid programs.

### **Growing numbers of uninsured and underinsured**

In Minnesota, the ranks of the uninsured seen at community health clinics have been increasing 10 percent annually since the 1990s, says Watson. These centers collectively serve 180,000 patients per year — 38 percent of them uninsured, 43 percent in public insurance programs like Medical Assistance/Medicaid and MinnesotaCare, and 6 percent on Medicare (for age 65-plus). About 3.5 percent of patients get GAMC.

The rest may have private insurance but not dental coverage. Their deductibles and out-of-pocket expenses are steep enough that they seek primary care on a sliding fee scale at community centers. They are among the "underinsured," people whose out-of-pocket health expenses exceed 10 percent of household income. Nationwide, the number of underinsured adults climbed to 25 million in 2007, up from 16 million in 2003, according to a 2008 report from The Commonwealth Fund.

Add those numbers to the estimated 46 million to 50 million people without any insurance in the nation, and you see why there's a concerted push for some sort of universal coverage.

The latest figures available for Minnesota show that 6.7 percent of adults in the state were considered underinsured in 2004 compared with 7.8 percent in the nation, according to data from the State Health Access Data Assistance Center at the University of Minnesota. Children fare better: 3.8 percent of Minnesota children are in families paying more than 10 percent out of pocket compared with a 2.9 percent national average. Minnesota's uninsured rate was 7.4 percent or about 380,000 people, though other estimates have pushed the percentage higher.

### **Treating older patients, chronic conditions**

At the nonprofit Neighborhood Involvement Program's center in Minneapolis, medical clinic supervisor Donna Litecky says she doesn't have hard numbers but she has noticed a shift in the patient population in her 14 years there.

When the privately funded clinic first opened about 30 years ago, uninsured patients typically were in their 20s and 30s. Now the patient population is older, but not quite old enough to qualify for Medicare.

"Part of that is they're losing their jobs or they only have catastrophic insurance, so they don't have a primary care site anymore," she said. "As they get older, they have more chronic conditions — hypertension, high cholesterol, diabetes."

Some are showing up with acute conditions because they haven't been able to afford medication — insulin for diabetes, for example — to treat the ailments.

Like others running community clinics, Litecky would like to see patients receive a "continuum of health care" throughout their lives. There's growing emphasis nationwide on establishing "health-care homes" for patients.

"The way I look at health care is preventative health care," says Litecky, a registered nurse. "If we would fund preventative health care, we would save trillions of dollars on patients."

### **Doing a lot with a little**

The clinic, which sees 8,000 to 10,000 uninsured and underinsured patients a year, receives no federal aid but relies instead on grants from agencies like the United Way, from patient fees assessed on a sliding scale, and from volunteer physicians, specialists, nurse practitioners and nurses in addition to paid staff. "We've learned in this clinic how to do a lot with very little money," she says.

With cuts to state programs and hospitals, Litecky is particularly worried about whether Hennepin County Medical Center will be able to handle referrals for patients who need more than primary care.

While Litecky has the ear of a journalist, she wants to clear up a few misconceptions about uninsured patients. "Every once in a while, I'll hear from somebody, 'Well, I have insurance — what's wrong with them that they can't get it?'"

"I think there's a public misconception that people who don't have insurance are using the system," she said. "That's not my experience. It is the working poor or people who are self-employed or who work in service industries that don't have insurance. They would really like to have health insurance, but either their employer doesn't offer it or it's unaffordable."

"When some businesses downsize, they cut people back to part time so that the health benefit is not offered. Or they lose their jobs, which is not their fault. Some people can't get insurance because they might have a pre-existing condition which, again, is not their fault. If you have high blood pressure, you have high blood pressure. It's not like you asked for it."

### **Navigating the labyrinth of aid**

At least half of uninsured Minnesotans are eligible for a public insurance program but may not realize it, says Debra Holmgren, president and executive director of Portico Healthnet.

"If it was easy to get on a program, they would already be enrolled," Holmgren says.

Remember that labyrinth mentioned above?

The St. Paul nonprofit agency's mission is to help qualify the uninsured for public programs, a herculean task for those who don't know the ropes. Without guidance, "some [of the uninsured] have gotten frustrated with the application process and given up," Holmgren says.

"The big barrier is it takes so long for applications to be processed," she says. "At the county level, a person can have a six-month wait; it's generally two to three months but they're just backed up."

For those who don't qualify for a public program, Portico offers interim health coverage — typically for the unemployed or underemployed between jobs and benefits — through contracts with various clinics for \$25 to \$50 a month. Eligibility is limited to those with household incomes at or below 275 percent of federal poverty guidelines.

### **700 people on waiting list**

Typically, Portico has 500 people on a six-month waiting list for the coverage. Now, the list has grown to 700 people facing a wait of 18 months.

"What this tells you is the opportunities to find better situations aren't as plentiful because of the job market," Holmgren says.

Though Portico has focused on residents in the east metro counties of Ramsey, Dakota and Washington, grants from United Way, UCare and UnitedHealth Group have enabled it to expand into Hennepin County.

Last year, Portico helped to enroll 2,000 people in public health programs and about 1,200 in its coverage program. Calls for help have doubled in the first three months of this year compared with the same period in 2008.

Funding for the agency is stable at the moment. "But, like everyone else, we're waiting to see to what extent we might be cut back because foundations have less money to give out," Holmgren says. "We're hoping our hospital partners' commitments won't change even though they're likely to be hit with hardships from legislative cuts. Right now, it's a waiting game."

### **Waiting for health care reform**

CUHCC patient Della Jones of south Minneapolis sits in the clinic's waiting room and reflects on health reform.

For 11 years, Jones worked as a full-time cashier and supervisor at a liquor store that didn't provide health benefits for its three-dozen workers. Since becoming unemployed two years ago, she now qualifies for insurance through a program administered by Hennepin County. She's been a CUHCC patient for six months and is "very satisfied" with the care.

"When I didn't have insurance, I went unseen or the bills piled up," says Jones. "I once had a sore on my foot that turned into an infection because it didn't get seen."

She supports a public plan that might become available in health reform. "I say give it to them; everybody should be covered."

Across the waiting room sits 30-year-old Al Voges, who says he's a "struggling self-employed comedian" and waiting to get his ears cleaned. This is a minor annoyance compared to an accident 12 years ago. He spent six weeks in a coma and more than six months in rehab after his vehicle was hit by a grain truck.

His parents, who owned a convenience store in Cortland, Minn., couldn't afford any of it. Fortunately, he had purchased auto insurance the week before the accident — at his mother's insistence. And he qualified for a public program while in the hospital. "If I didn't have it, I'd be dead or mortally wounded — which is dead," notes Voges, trying to get a laugh from the scribe.

### **'You're signing your own death warrant'**

Seriously, he's unsure whether it would be fair for people who are privately insured to pay more when others might get a less expensive, tax-supported public option. Still, he concedes: "To not be insured, you're signing your own death warrant."

Sixty percent of CUHCC's patients — 72 percent of whom are people of color, immigrants and refugees — receive care through Medicaid. With an annual budget of \$12 million, the clinic also receives funding

from a number of sources, including the University of Minnesota, which supplies dental students to help with patients as well as other support.

Interestingly, this clinic is somewhat of an economic bellwether, seeing the first wave of distress a couple of years ago in the surrounding poor neighborhoods.

"When the foreclosures began, we immediately saw an increase in the number of patients coming to the clinic," said Mills. "Today, we have people from throughout the Twin Cities seeking affordable health care, and they are often coming with acute needs. We, along with our safety net partners, struggle to absorb the numbers of folks without health care coverage."

But she remains hopeful. "Health care reform has finally emerged as a critical issue on the national front. We have hope that changes in health care for the future will better support those without insurance and those on Medicaid."

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